Most Favored Nation Drug Pricing in the US: Why a National HTA Agency Is Needed Beyond International Reference Pricing

HPR211

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Background

- **International reference pricing** (**IRP**) is widely used to inform pharmaceutical prices by referencing prices in other countries. In the United States (US), international price referencing gained prominence with the 2018 International Pricing Index (IPI) proposal, which sought to align **Medicare Part B** payment for selected drugs more closely with prices in 16 other developed countries.[1]
- In 2020, **Centers for Medicare & Medicaid Services** (**CMS**) proposed the **Most Favored Nation** (**MFN**) **Model**, under which **Medicare Part B** payment would have incorporated the lowest price, adjusted for purchasing power, among eligible **Organization for Economic Co-operation and Development** (**OECD**) countries.[2] The model was blocked by a federal court and ultimately was not implemented.[3]
- The **Inflation Reduction Act** (**IRA**) of 2022 introduced a separate approach, establishing Medicare drug price negotiation rather than an international reference pricing mechanism.[4]
- Interest in **MFN** subsequently re-emerged in 2025, when an Executive Order directed the US Administration to pursue MFN price targets for prescription drugs.[5] MFN effectively imports prices from health systems with different approaches to health technology assessment (HTA), willingness-to-pay (WTP), healthcare costs, and treatment pathways.
- Countries commonly used as **MFN** references, including **Germany**, **France**, and **the United Kingdom** (**UK**), make pharmaceutical pricing and reimbursement decisions within country-specific HTA and institutional frameworks. Consequently, the prices used as **MFN benchmarks** may reflect value judgements and economic conditions that are not directly applicable to the US. The extent to which international prices can serve as appropriate benchmarks for US pricing therefore warrants consideration.

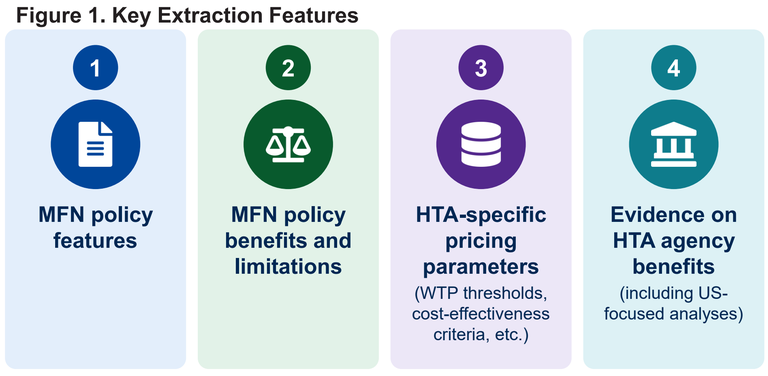
Objective

- To examine MFN's structural limitations and the case for a national US HTA agency.

Methods

- A targeted literature review used PubMed, Google Scholar, and grey literature from CMS, the White House Council of Economic Advisers, Institute for Clinical and Economic Review (ICER), and HTA agencies including National Institute for Health and Care Excellence (NICE; UK), Gemeinsamer Bundesausschuss (G-BA; Germany), and Haute Autorité de Santé (HAS; France).
- Records published 2016–2026 in English were included, extracting the following information (**Figure 1**):

Figure 1. Key Extraction Features



Results

MFN policy features

- The review identified three distinct CMS international-reference-pricing models: **GENEROUS**, **GLOBE**, and **GUARD**. Although all three use international drug prices as a benchmark, they differ in the US program targeted, manufacturer participation, and method used to derive the international benchmark. As of August 2026, GENEROUS has been launched, whereas GLOBE and GUARD remain proposed models (**Table 1**).
- **GENEROUS (Medicaid)**
  - A five-year model launched in 2026, with voluntary participation by manufacturers and states. Manufacturers provide supplemental Medicaid rebates intended to bring net prices closer to an international benchmark. The benchmark is the second-lowest PPP-adjusted net price among eight countries: **Canada, Denmark, France, Germany, Italy, Japan, Switzerland, and the UK**.[6] PPP adjustment accounts for differences in purchasing power between the US and reference countries.
- **GLOBE (Medicare Part B)**
  - A proposed model for selected **physician-administered drugs** and **biologics**. GLOBE uses a 19-country OECD reference basket (**Table 1**).[7,8] Eligible countries must have PPP-adjusted GDP per capita of at least 60% of the US level and total PPP-adjusted GDP of at least $400 billion. CMS proposed two benchmark methods: (1) the lowest PPP-adjusted country-level price and (2) a volume-weighted average of manufacturer-reported international net prices, with the higher of the two generally used as the benchmark.

Results (continued)

- **GUARD (Medicare Part D)**
  - A proposed model applying to selected **pharmacy-dispensed drugs**. GUARD uses the same 19-country reference basket and economic eligibility criteria as GLOBE.[9,10] Rather than directly establishing a payment price, the model would incorporate the international benchmark into the **Medicare Part D inflation-rebate** calculation, with manufacturers facing a larger rebate when US prices exceed the applicable international benchmark.[9,10]

Table 1. Key Features of US MFN Pricing Models

FEATURE	GENEROUS *(GENErating cost Reductions fOr U.S. Medicaid)*	GLOBE *(Global Benchmark for Efficient Drug Pricing)*	GUARD *(Guarding U.S. Medicare Against Rising Drug Costs)*
U.S. program	Medicaid	Medicare Part B (physician-administered drugs)	Medicare Part D (pharmacy-dispensed drugs)
Status (Aug 2026)	Launched (Jan 2026)	Proposed (Dec 2025)	Proposed (Dec 2025)
Participation	Voluntary (manufacturers and states)	Proposed mandatory	Proposed mandatory
Reference countries	8 countries: Canada, Denmark, France, Germany, Italy, Japan, Switzerland, UK	19 OECD countries[1]	19 OECD countries[1]
International benchmark	Second-lowest PPP-adjusted net price among 8 countries	Higher of: (1) lowest PPP-adjusted country price or (2) volume-weighted average international net price	International benchmark incorporated into inflation-rebate calculation
Pricing mechanism	Supplemental manufacturer rebate to states	Manufacturer rebate / payment adjustment	Modified manufacturer inflation rebate
Key objective	Bring Medicaid net prices closer to international prices	Reduce U.S. Medicare Part B prices relative to international benchmarks	Reduce excessive U.S. Part D prices relative to international benchmarks

PPP ADJUSTMENT IS CENTRAL ACROSS ALL THREE MODELS:
PPP is used to select economically comparable countries and adjust international prices before application in each model's pricing mechanism.

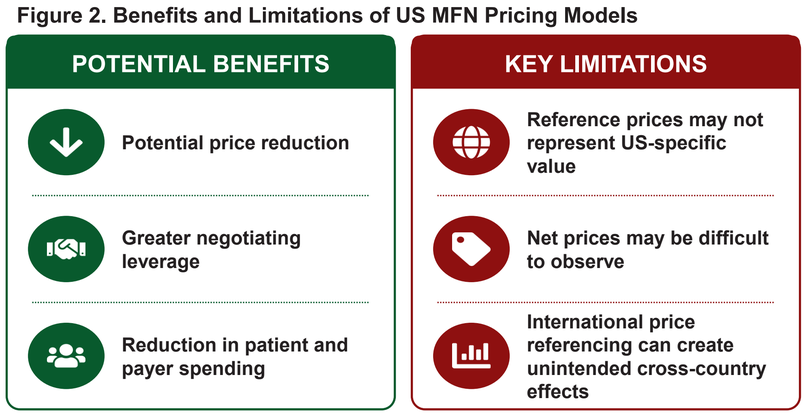
[1] 19 OECD countries: Australia, Austria, Belgium, Canada, Czechia, Denmark, France, Germany, Ireland, Israel, Italy, Japan, the Netherlands, Norway, South Korea, Spain, Sweden, Switzerland, UK

MFN = Most-Favored-Nation; PPP = purchasing power parity.

MFN policy benefits and limitations

- **Benefits**
  - **Price reduction and cost containment:** International benchmarking can place downward pressure on pharmaceutical prices, particularly where US prices are substantially higher than prices in reference countries (**Figure 2**).[11]
  - **Greater negotiating leverage:** Using prices observed in other markets can provide policymakers with an external benchmark when negotiating manufacturer prices rather than relying solely on domestic pricing arrangements.
  - **Reduction in patient and payer spending:** The current US MFN framework explicitly seeks to reduce the gap between US and international drug prices and thereby reduce spending for government programs and beneficiaries. The 2026 White House assessment reports that the Administration's voluntary MFN agreements were intended to generate substantial savings for patients and government programs.[12]
- **Limitations**
  - **Reference prices may not represent US-specific value:** International prices are determined within country-specific healthcare systems, including different HTA methodologies, reimbursement rules, healthcare costs, treatment pathways, and approaches to valuing health outcomes. Consequently, an international price may reflect foreign economic and policy conditions rather than the value of the medicine in the US healthcare system.[13,14]
  - **Net prices may be difficult to observe:** International list prices may not reflect actual transaction prices because of confidential rebates, discounts, taxes, and other purchasing arrangements. The World Health Organization therefore recommends that reference prices account for discounts and rebates where possible and that price data be verifiable.[14,15]
  - **International price referencing can create unintended cross-country effects:** Evidence from ERP systems suggests potential launch delays, price convergence, price instability, and indirect effects on pricing strategies. Manufacturers may have incentives to delay launches in lower-price countries or avoid offering lower prices where those prices could subsequently be referenced elsewhere.[11,16]

Figure 2. Benefits and Limitations of US MFN Pricing Models



HTA-specific pricing parameters

- The HTA frameworks used in key MFN reference countries differ in their economic perspective, evaluation methods, outcome measures, and approaches to cost-effectiveness thresholds. **NICE** in **the UK** uses cost-utility analysis based on QALYs to appraise economic value, whereas **G-BA** in **Germany** assesses the added clinical benefit of a new medicine versus an appropriate comparator under the AMNOG process, and this benefit assessment informs price negotiation. **HAS** in **France** may use cost-utility or cost-effectiveness analyses depending on the impact on health-related quality of life (**Table 2**).

Results (continued)

- **NICE** applies an explicit cost-effectiveness range of £25,000–£35,000 per QALY, while **G-BA and HAS** do not use a single explicit cost-effectiveness threshold. Economic perspectives also differ, ranging from the **NHS and Personal Social Services perspective in the UK**, to a **healthcare system perspective in Germany**, and a broader **collective perspective in France**.
- These differences indicate that international prices used as MFN benchmarks are generated within distinct approaches to assessing and valuing health technologies, rather than representing a common measure of willingness to pay for pharmaceutical value.

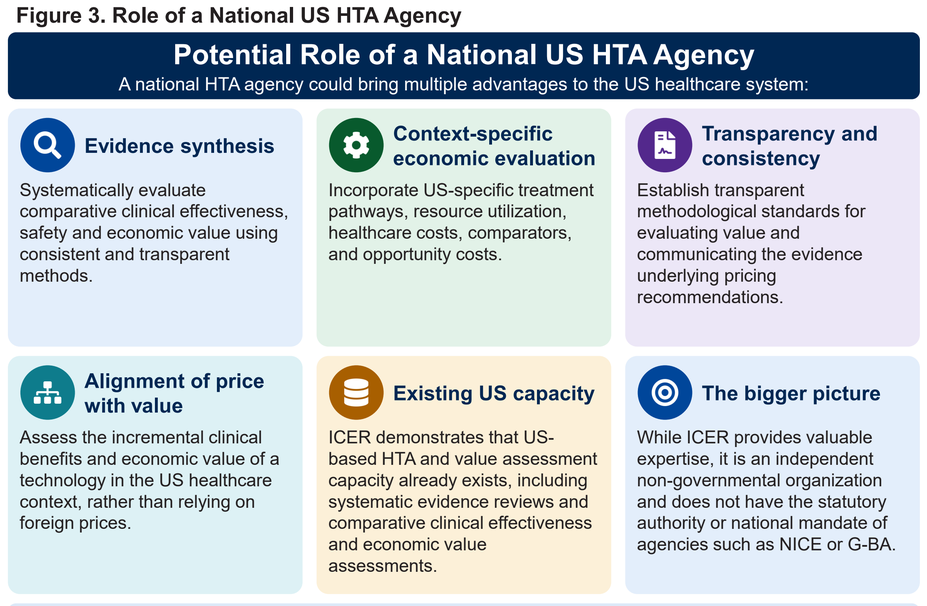
Table 2. Key HTA and Economic Evaluation Parameters in MFN Reference Countries

HTA parameter	NICE (UK)	G-BA (Germany)	HAS (France)
Economic perspective	NHS and Personal Social Services (PSS)	Healthcare system	Collective (domestic, healthcare and medico-social)
Assessment approach	Cost-utility analysis (economic appraisal)	Benefit assessment: added clinical benefit versus an appropriate comparator (AMNOG)	Cost-utility or cost-effectiveness analysis, depending on HRQoL impact
Primary outcome	QALYs	Extent of added benefit (mortality, morbidity, HRQoL, safety)	QALYs or life-years, depending on evaluation type
WTP / cost-effectiveness threshold	£25,000–£35,000 per QALY gained (from April 2026)	No explicit threshold; added benefit informs price negotiation	No single explicit threshold

US national HTA agency benefits

- Unlike **MFN,** which uses international prices as a benchmark, health technology assessment provides a systematic and multidisciplinary approach to evaluating the clinical and economic value of a technology and informing healthcare decision-making (**Figure 3**).[17,18]
- A **national US HTA framework** could therefore complement **MFN** by assessing value using evidence and parameters relevant to the US healthcare system. A national HTA agency could provide a consistent framework for evidence synthesis, economic evaluation, and value assessment, incorporating US-specific treatment pathways, resource use, healthcare costs, comparators, and other relevant considerations.[17,18]
- This could support greater consistency and transparency in how evidence is evaluated and communicated across the healthcare system. The US already has experience with HTA through organizations such as **ICER**, which conducts systematic evidence reviews and value assessments using a defined methodological framework.[19,20]
- However, ICER is an independent non-governmental organization, whereas formal national HTA systems in other countries operate within established institutional frameworks.[19] This highlights the potential role of a national framework for institutionalized US-specific value assessment.

Figure 3. Role of a National US HTA Agency



Conclusions

- MFN provides an international price benchmark, but does not independently assess the clinical or economic value of medicines in the US.
- MFN reference prices are shaped by country-specific HTA frameworks, healthcare costs, treatment pathways, and approaches to valuing health outcomes.
- GDP-PPP improves price comparability but cannot substitute for US-specific health economic evaluation or capture domestic value considerations.
- A nationally mandated US HTA framework could complement MFN by providing transparent, consistent, and outcome-oriented assessment of pharmaceutical value.

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